
 Colorado Health Plan Description Form Kaiser Permanente HMO Effective January 1, 2004 																																			
PART A: TYPE OF COVERAGE																																			
1 TYPE OF PLAN	Health Maintenance Organization (HMO)																																		
2 OUT-OF-NETWORK CARE COVERED? ¹	Only for Emergency Care																																		
3 AREAS OF COLORADO WHERE PLAN IS AVAILABLE	<p>Denver/Boulder: portions of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld counties within the following zip codes:</p> <p>80001-7, 80010-22, 80024-28, 80030, 80031, 80033-38, 80040-42, 80044-47, 80102, 80104, 80107-13, 80116-17, 80120-31, 80134-35, 80137-38, 80150-51, 80154-55, 80160-63, 80201-12, 80214-39, 80241, 80243-44, 80246-52, 80254-56, 80259, 80260-66, 80270-71, 80273-75, 80279-81, 80290-95, 80299, 80301-10, 80314, 80321-23, 80328-80329, 80401-3, 80421-22, 80425, 80427, 80433, 80437, 80439, 80452-55, 80457, 80465-66, 80470-71, 80474, 80481, 80501-4, 80510, 80513-14, 80516, 80520, 80530, 80533-34, 80537-40, 80542-44, 80600-03, 80614, 80621, 80623, 80640, 80642-43, 80651.</p> <p>Colo. Spgs.: portions of Douglas, El Paso, Fremont, Park, Pueblo and Teller counties within the following zip codes:</p> <p>80106, 80118, 80132-33, 80808-09, 80813-14, 80816-17, 80819-20, 80827, 80829, 80831-33, 80840-41, 80860, 80863-64, 80866, 80901, 80903-22, 80925-26, 80928-37, 80940-47, 80949-50, 80960, 80962, 80970, 80977, 80995, 80997, 81007-08, 81212, 81240.</p>																																		
PART B: SUMMARY OF BENEFITS																																			
<p>Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage.</p>																																			
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11	PRESCRIPTION DRUGS Level of coverage and restrictions on	\$15 generic/\$40 brand up to a 30-day supply *for more details, please see attached addendum. for drugs on our approved list, please contact your Medical Office Pharmacist
12	INPATIENT HOSPITAL	\$1,000 copay per admission/Individual
13	OUTPATIENT/AMBULATORY SURGERY	\$150 per procedure copay
14	LABORATORY AND X-RAY	Diagnostic Lab and X-ray - No copay (100% covered) Therapeutic X-ray - \$50 per visit copay MRI/CAT/PET - \$100 per procedure copay
15	EMERGENCY CARE ³	\$100 per visit copay at a Kaiser Permanente designated Plan or non-Plan emergency room, waived if admitted as an inpatient. Payment of non-Plan emergency claims is limited to usual reasonable and customary charges.
16	AMBULANCE	20% up to a maximum of \$500 per trip
17	URGENT, NON-ROUTINE, AFTER HOURS CARE	\$100 per visit copay at a designated Kaiser Permanente emergency room \$30 per visit copay at a Kaiser Permanente medical office during office hours. \$50 per after hours visit copay at designated Kaiser Permanente medical offices
18	BIOLOGICALLY-BASED MENTAL ILLNESS ⁴ CARE	Coverage is no less extensive than the coverage provided for any other physical illness.
19	OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	50% copay per admission - up to 45 days each calendar year \$30 copay each visit up to 20 visits each calendar year. Group visits will be charged at half the copay of an individual visit, rounded down to the nearest dollar. Two group visits will count as one individual visit.
20	ALCOHOL & SUBSTANCE ABUSE a) Inpatient Medical Detoxification b) Inpatient Residential Rehabilitation c) Outpatient Chemical Dependency	\$1,000 copay per admission/Individual 50% coinsurance up to 45 days each \$30 copay per visit up to 20 visits each calendar year. Group visits will be charged at half the copay of an individual visit, rounded down to the nearest dollar. Two group visits will count as one individual visit.
21	PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY a) Inpatient care b) Outpatient care	\$1,000 copay per admission/Individual for conditions subject to significant improvement within two months \$30 per visit copay for up to two months per condition, or up to 20 visits per condition if 20 or more visits are not received within two months, for conditions subject to significant improvement within two months *Therapy for congenital defects and birth abnormalities is covered for children up to age five for both acute and chronic conditions.
22	DURABLE MEDICAL EQUIPMENT	No copay up to \$2,000 each calendar year within the Service Area. Prosthetic arms and legs covered at no copay (100% covered) with no annual maximum. See policy for types and circumstances of coverage
23	OXYGEN	20% copay
24	ORGAN TRANSPLANTS a) Major Organ Transplant	\$1,000 copay per admission/Individual - no waiting period. Covered transplants are limited to kidney, kidney/pancreas, pancreas, heart, heart-lung, lung, some bone marrow, cornea and liver, small bowel/small bowel and liver
25	HOME HEALTH CARE	No copay (100% covered) for prescribed medically necessary home health services. Not covered outside the Service Area
26	HOSPICE CARE	No copay (100% covered) for home-based hospice care. Not covered outside the Service Area.

27	SKILLED NURSING FACILITY CARE	No copay (100% covered) for up to 100 days for prescribed skilled nursing facility services at approved skilled nursing facilities. Not covered outside the Service Area
28	DENTAL CARE	No coverage provided
29	VISION CARE	\$30 per primary care office visit copay; for vision exam Hardware not covered
30	CHIROPRACTIC CARE	\$30 copay for 20 visits
31	SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Travel Clinic for pre-travel health risk assessments, immunizations and prescriptions; Mail-order Pharmacy; post-mastectomy breast reconstruction including services to attain breast symmetry, prostheses and services due to complications; Health education classes including Smoking Cessation, Stress Management, Women's Health and Diet and Nutrition; Special Services Hospice program for persons who have not yet chosen hospice care

PART C: LIMITATIONS AND EXCLUSIONS

32	PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED ⁵	Not applicable. Plan does not impose limitation periods for pre-existing conditions.
33	EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
34	HOW DOES THE POLICY DEFINE A "PREEXISTING CONDITION"?	Not applicable. Plan does not exclude coverage for pre-existing conditions
35	WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g. employer). Review them to see if a service or treatment you may need is excluded from the policy

PART D: USING THE PLAN

36	Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	Yes
37	Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes
38	If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No
39	What is the main customer service number?	(303) 338-3800
40	Whom do I write/call if I have a complaint or want to file a grievance ⁶	Customer Service Center 2500 S. Havana Street Aurora, CO 80014 Telephone (303) 338-3800
41	Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202
42	To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy forms DEDEOC-DENCOS(07-03) and GA-DENCOS(01-03) Large Group

PART E: COST

43	What is the cost of this plan?	Employee Portion	State Contribution	Full Premium
	Employee only	\$93.64	\$156.06	\$246.40
	Employee + 1 dep.	\$263.56	\$232.52	\$492.78
	Employee + 2 or more dep.	\$366.74	\$326.46	\$689.90

PART F: PHYSICIAN PAYMENT METHODS, AND PLAN EXPENDITURES FOR HEALTH

Any person interested in applying for coverage, or who is covered by or who purchased coverage under this plan, may request answers to the

- What are the three most frequently used methods of payment for primary care physicians?
- What are the three most frequently used methods of payment for physician specialists?
- What other financial incentives determine physician payment?
- What percentage of total Colorado premiums are spent on health-care expenses as distinct from administration and profit?

Endnotes:

1. "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).
2. "Out of Pocket Maximum" The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan.
3. "Emergency Care" means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life-or-limb threatening emergency existed.
4. "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.
5. Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.
6. Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

Selected Benefit Descriptions
Colorado Health Plan Description Form Addendum
Kaiser Foundation Health Plan of Colorado
Plan 230
State of Colorado, Group 225

Benefit	Benefit Level
<p>11 PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions</p>	<p>\$15 Generic / \$40 Brand - prescribed covered drugs on Health Plan's formulary - for up to a 30-day supply for maintenance drugs or part of a 30-day supply for non-maintenance drugs. Certain drugs that have a significant potential for waste and diversion will be provided for up to a 30-day supply, at the applicable prescription drug Copayment, and are not available by mail order service.</p> <p>If a Member requests a name-brand drug when a generic equivalent drug is prescribed, the Member must pay \$40.00, plus any difference in price between the preferred generic equivalent drug prescribed or authorized by the Physician and the requested brand drug. If the brand drug is prescribed due to medical necessity, the Member pays only the brand Copayment.</p> <p>Mail Order Service: Denver/Boulder Service Area: Refills will be mailed through Direct Rx, Kaiser Permanente's mail order prescription service. Refills of prescribed drugs may be obtained for up to a 90-day supply by mail order, at a charge of two prescription drug Copayments. Reorder envelopes are available at any Kaiser Permanente Pharmacy and are included in every prescription order mailed by Direct Rx. Refills will be mailed by first-class U.S. Mail with no charge for postage and handling. Direct Rx can be used 24 hours a day by calling (303) 344-5077.</p> <p>Colorado Springs Service Area: Refills of maintenance drugs may be filled by calling our convenient mail order prescription service, ScripPharmacy, which is available 24 hours a day. Contact ScripPharmacy customer service representatives at (800) 677-4323 for more information. Refills will be mailed by first class U.S. Mail with no charge for postage and handling. Maintenance drug refills may be obtained by mail order for up to a 90-day supply, at a charge of two prescription drug Copayments, if prescribed by a Plan Physician. Maintenance drugs are determined by Health Plan.</p>